Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $1,813.78 for date of service, 07/26/01.

   b. The request was received on 07/03/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. UB-92(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Example EOBs from other Insurance Carriers
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. ASC Methodology
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 08/12/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 08/13/02. The response from the insurance carrier was received in the Division on 08/26/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 08/05/02

   "We are appealing the amount disallowed on the above mention [sic] claim. These charges are for **FACILITY FEES,** not professional fees. We feel that 25% paid on a left trigger finger release is not fair or reasonable. We feel that (Carrier) should reimburse us more appropriately as $451.57 does not cover our cost to perform this surgery…..(Carrier) has unfairly reduced our bill when other worker's compensation carriers' have established that our charges are fair and reasonable….Enclosed are examples of bills for the same type of treatment of other patients and their insurance companies interpretation of fair and reasonable as shown by the amounts paid."

2. Respondent: Letter dated 08/26/02

   "(Requestor) has provided an itemization of charges. This appears to be nothing more than an unbundling of its charges. (Requestor) lists the 'charges' for certain items allegedly used in the procedure. However, (Requestor) does not list the its [sic] cost of these items….A provider's costs do not determine the reasonableness of its charges. If each provider could charge whatever amount was necessary to cover its costs, there would be no way to control costs….(Requestor) has offered no evidence that (Carrier's) reimbursement is not fair and reasonable….To comply with Rule 133.304 and avoid inconsistent reimbursement, (Carrier), through (Auditor), has developed a methodology to reimburse ASC's in a fair and reasonable manner. (Auditor) has analyzed procedures performed at ASC's and grouped them in accordance with their intensity….(Auditor) surveyed the six states that have fully adopted this type of reimbursement methodology and assigned fees to each of the eight levels….(Auditor) applied the HCFA wage index factor to the base reimbursement to arrive at a total reimbursement. (Requestor) is located in Hurst. There is no wage index for Hurst. Applying the State wage index results in…reimbursement of facility charges….(Carrier's) payment methodology complies with the Labor Code and (Requestor) was not entitled to additional reimbursement."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/26/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $2,265.35 for services rendered on date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $451.57 for services rendered on date of service in dispute above.

5. The Carrier's EOBs denied any additional reimbursement as "705: M - No MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area."

6. Per the Requestor's Table of Disputed Services, the amount in dispute is $1,813.78 for services rendered on the date of service in dispute above.

7. The facility provided O.R. services, pharmaceutical products, medical and surgical supplies, non-sterile supplies, IV therapy, Radiology services, anesthesia equipment, EKG/ECG monitor, and Recovery Room services.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The provider has submitted several examples of other Carrier's EOBs for charges billed for a similar procedure. However, the carrier has submitted documentation asserting that they have paid a fair and reasonable reimbursement. Respondent has submitted an explanation of their payment methodology.

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

1. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

2. reference its method in the claim file; and

3. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;".

The carrier asserts that EOBs do not constitute a pattern substantiating fair and reasonable; and likewise, the requestor's example EOBs do not refute that the Respondent has developed and consistently applied it's methodology to determine fair and reasonable.

Per Exhibit I, (Carrier's) methodology incorporates information from 6 states, which have adopted a system to determine ASC charges based on intensity levels. The range is from 1 (low) to 8 (high), which is determined based on where the CPT Code falls in the HCFA intensity grouper list. (Carrier) averaged the payments in each level for the 6 states and designated this as the base fee for each intensity level. (Carrier) also takes into account local economic factors and applies HCFA' s wage index factor to the base fees. If the specific area is not addressed in the wage index, (Carrier) uses the state average.

(Carrier) sums up its methodology, indicating it generates fair and reasonable fees utilizing a well accepted intensity grouper and average prevailing usual and customary reimbursement from a geographically diverse set of workers' compensation fee schedules. There is no discounting from mean payments; a local economic adjustor is applied to the reimbursement; and additional payments are made for extraordinary supplies and lab testing.

The Respondent included attachments to further reflect its methodology. Attachment A indicates grouper numbers, CPT codes, and range of charges. Attachment B compares Medicare rates for ASC bills with states that have a similar payment schedule. Attachment C is the wage index used to take into account geographical differences.

Exhibit 2 provides a list of Texas ASC centers (bills processed in May and June 2000) that have been paid based on (Carrier's) methodology. In Exhibit 3, (Carrier) indicates that it has canvassed other payers in the system who reimburse on the average of 110% to 140% of Medicare allowable rates and even though Kemper does not use Medicare, it compares favorably because it pays an average of 150% of Medicare.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence. As the requestor, the health care provider has the burden to provide documentation that "…discussed, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement…." pursuant to TWCC Rule 133.307 (3) (g) (D). While the requestor has attached several copies of example EOBs, they have failed to demonstrate how this documentation is utilized in their determination of the amount billed. Respondent has provided their methodology, which conforms to the additional criteria of Sec. 413.011 (d).

The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. In this case, the Requestor has failed to support their position that the amount billed is fair and reasonable and the Respondent has submitted enough information to support the argument that the amount reimbursed represents a fair and reasonable reimbursement. Therefore, **no additional** reimbursement is recommended.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D); and (j) (1) (F).

The above Findings and Decision are hereby issued this 12th day of March 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division

DT/dt